medicaid services division. Approvals will be effective for 1 month intervals and reapproval must be obtained monthly.

(b) The department may require the provider to submit any appropriate medical and other documentation to support a request for authorization of the increment. Each calendar month, the provider must submit to the department, together with reporting forms and according to instructions supplied by the department, time records of nursing services provided to the resident during a period of five consecutive days. The submitted time records must identify the amount of time care is provided by each type of nursing staff, i.e., licensed and non-licensed.

(c) The increment amount shall be determined by the department as follows. The department shall subtract the facility's current average medicaid case mix index (CMI) used for rate setting determined in accordance with ARM 37.40.320 from the CMI computed for the ventilator dependent resident, determined based upon the current minimum data set (MDS) information for the resident in order to determine the difference in case mix for this resident from the average case mix for all medicaid residents in the facility. The increment shall be determined by the department by multiplying the provider's direct resident care component by the ratio of the resident's CMI to the facility's average medicaid CMI to compute the adjusted rate for the resident. The department will determine the increment for each resident monthly after review of case mix information and five consecutive day nursing time documentation review.

(3) The department will reimburse for separately billable items at direct cost, with no indirect charges or mark-up added. For purposes of combined facilities providing these items through the hospital portion of the facility, direct cost will mean invoice price to the hospital with no indirect cost added.

(a) If the items listed in (1)(a) through (1)(de) are also covered by the medicare program and provided to a medicaid recipient who is also a medicare recipient, reimbursement will be limited to the lower of the medicare prevailing charge or the amount allowed under (2). Such items may not be billed to the medicaid program for days of service for which medicare Part A coverage is in effect.

(b) The department will reimburse for separately billable items only for a particular resident, where such items are medically necessary for the resident and have been prescribed by

a physician.

(4) Physical, occupational, and speech therapies which are not nursing facility services may be billed separately by the licensed therapist providing the service, subject to department rules applicable to physical therapy, occupational therapy, and speech therapy services.

(a) Maintenance therapy and rehabilitation services within the definition of nursing facility services in ARM 37.40.302, are reimbursed under the per diem rate and may not be billed separately by either the therapist or the provider.

(b) If the therapist is employed by or under contract with the provider, the provider must bill for services which are not nursing facility services under a separate therapy provider number.

(5) Durable medical equipment and medical supplies which are not nursing facility services and which are intended to treat a unique condition of the recipient which cannot be met by routine nursing care, may be billed separately by the medical supplier in accordance with department rules applicable to such services.

(6) All prescribed medication, including flu shots and tine tests, may be billed separately by the pharmacy providing the medication, subject to department rules applicable to outpatient drugs. The nursing facility will bill medicare directly for 100% reimbursement of influenza vaccines and their administration when they are provided to an eligible medicare Part B recipient. Medicaid reimbursement is not available for influenza vaccines and related administration costs for residents that are eligible for medicare Part B.

(7) Nonemergency routine transportation for activities other than those described in ARM 37.40.302(12), may be billed separately in accordance with department rules applicable to such services. Emergency transportation may be billed separately by an ambulance service in accordance with department rules applicable to such services.

(8) The provider of any other medical services or supplies, which are not nursing facility services, provided to a nursing facility resident may be billed by the provider of such services or supplies to the extent allowed under and subject to the provisions of applicable department rules.

(9) The provisions of (3) through (7) apply to all nursing

facilities, including intermediate care facilities for the mentally retarded, whether or not located in the state of Montana.

(10) Providers may contract with any qualified person or agency, including home health agencies, to provide nursing facility services. However, except as specifically allowed in these rules, the department will not reimburse the provider for such contracted services in addition to the amounts payable under ARM 37.40.307. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1996 MAR p. 1698, Eff. 6/21/96; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01.)

Extended Rehabilitation Unit (ERU) or Traumatic Brain Injured Program (TBI)

Program Criteria

Program developed to meet meeds of individuals who are not eligible for acute rehabilitation services but who are still unable to return to independent or home living. The program must provide individualized rehabilitation sustaining therapies and recreational opportunities.

All individuals appropriate for this program must be at Level II (Rancho Scale) or above and be alert to stimuli. The Rancho Scale is a cognitive functioning scale developed by the head injury treatment team at the Rancho Los Amigos Hospital and applies specifically to head injured people following injury.

Individuals referred and admitted to this unit shall demonstrate an ability to recognize, either on their own or with prompting when their behavior is inappropriate. People who demonstrate aggressive behaviors that are potentially dangerous to themselves or others are not appropriate for placement into this program. Those who are elopement risks or require locked units may not be appropriate. If these behaviors develop after admission into the

unit the facility reserves the right to discharge to a more appropriate setting or initiate acute intervention.

Services to be Provided:

This facility must provide a continuum of rehabilitation sustaining therapies and activities for post acute TBI survivors to provide quality of life in the least restrictive environment, provide opportunities for TBI survivors to achieve a higher level of independence, offer a peer group to individuals with newly acquired disabilities and supportive services as they learn to adapt and create an positive environment in which behavior intervention and retraining are a part of all programming.

All admissions into the unit will meet nursing facility level of care and will meet the requirements for level I and II criteria for PASARR. Minimum data set requirements and timelines will apply to all admissions into this unit.

Interim rates will be established on July 1, of the rate year from budget information submitted by the provider and an evaluation of the costs of providing care to the individuals in the respective unit. The rate established on July 1, will include all nursing facility services as specified in ARM 37.40.307 and all ancillary services specified in ARM 37.40.330 including all feeding solutions, as well as, increased staffing appropriate for the residents in the unit and any costs for physical therapy, speech therapy, occupational therapy, social worker services, psychological services. All of the above indicated costs must be provided within the interim daily rate established for the facility by employees of the facility or under contract with outside providers. The outside providers of these services may not bill medicaid for the provision of these services for any residents occupying a bed in this unit.

Services billable directly to medicaid when provided for residents in this unit and not included in the computation of the daily rate will be dental, pharmacy, physician visits, optometric, podiatry, lab and x-ray and durable medical equipment limited to wheelchairs, adaptations, specialized equipment and

repairs.

Reimbursement

This unit must operate as a distinct part unit from the rest of the nursing facility. Reimbursement levels will be established effective July 1, using an interim payment rate that will be subject to final settlement upon the submission of a cost report of at least six months of operation. Upon submission of a final cost report all costs must meet the allocability criteria and reasonableness established in ARM 37.40.345, 346 and 347.

Settlement of costs will be within a lower limit and an upper limit established as follows:

If the unit provides the required services for less than the interim rate times 95 percent, the lower limit, the facility will be allowed to maintain all amounts between the lower limit and the actual settled cost per day for provision of the services through the settlement process.

If the unit provides the required services for an allowable cost per day between the interim rate times 95 percent and the interim rate time 105 percent the facility will receive their actual allowable cost per day through the settlement process.

If the unit provides the required services for an allowable cost per day in excess of the interim rate times 105 percent, the upper limit, they will receive 100 percent of their cost up to the upper limit through settlement and any allowable costs in excess of the upper limit will be settled at 75 percent of the incurred costs through the settlement process.

Maximum occupancy in the unit will be 19 residents. The facility will be required to maintain a 90 percent occupancy for reimbursement purposes in this unit. If the unit operates at less than 90 percent an assumed 90 percent occupancy will be utilized in the final rate settlement process for this facility.

37.40.331 ITEMS BILLABLE TO RESIDENTS (1) The department

will not pay a provider for any of the following items or services provided by a nursing facility to a resident. The provider may charge these items or services to the nursing facility resident:

(a) gifts purchased by residents;

(b) social events and entertainment outside the scope of the provider's activities program;

(c) cosmetics and grooming items and services in excess of those for which payment is made by medicare or medicaid;

(d) personal comfort items, including tobacco products and accessories, notions, novelties, and confections;

(e) personal dry cleaning;

(f) beauty shop services;

(g) television, radio and private telephone rental;

(h) less-than-effective drugs (exclusive of stock items);

(i) vitamins, multivitamins, vitamin supplements and calcium supplements;

(j) personal reading materials;

(k) personal clothing;

(l) flowers and plants;

(m) privately hired nurses or aides;

(n) specially prepared or alternative food requested instead of food generally prepared by facility; and

(o) the difference between the cost of items usually reimbursed under the per diem rate and the cost of specific items or brands requested by the resident which are different from that which the facility routinely stocks or provides (e.g., special lotion, powder, diapers);

(2) Services provided in private rooms will be reimbursed by the department at the same rate as services provided in a double occupancy room.

(a) A provider must provide a medically necessary private room at no additional charge and may not bill the recipient any additional charge for the medically necessary private room.

(b) A provider may bill a resident for the extra cost of a private room if the private room is not medically necessary and is requested by the resident. The provider must clearly inform the resident that additional payment is strictly voluntary. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 1385, Eff. 10/1/93;

AMD, 1998 MAR p. 1749, Eff. 6/26/98; TRANS, from SRS, 2000 MAR p. 489.)

Rules 32 through 35 reserved

37.40.336 REIMBURSEMENT FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (1) For intermediate care facility services for the mentally retarded provided in facilities located in the state of Montana, the Montana medicaid program will pay a provider a per diem rate equal to the actual allowable cost incurred by the provider during the fiscal year, determined retrospectively in accordance with ARM 37.40.345 and 37.40.346, divided by the total patient days of service during the rate year, minus the amount of the medicaid recipient's patient contribution, subject to the limits specified in (2)(a) and (b).

(2) Payments under (1) may not exceed the following limits:

(a) Final per diem payment rates for base years shall be as specified in (1), without application of any further limit. Base years are even-numbered state fiscal years, i.e., state fiscal years 1994, 1996 and subsequent even-numbered years.

(b) Final per diem rates in non-base years are limited to the final per diem rate for the immediately preceding base year indexed from June 30 of the base year to June 30 of the rate year. The index is the final medicare market basket index applicable to the non-base year. Non-base years are odd-numbered state fiscal years, i.e., state fiscal years 1993, 1995 and subsequent odd-numbered years.

(3) All ICF/MR providers must use a July 1 through June 30 fiscal year for accounting and cost reporting purposes.

(4) Prior to the billing of July services each rate year, the department will determine an interim payment rate for each provider. The provider's interim payment rate shall be determined based upon the department's estimate of actual allowable cost under ARM 37.40.345, divided by estimated patient days for the rate year. The department may consider, but shall not be bound by, the provider's cost estimates in estimating actual allowable costs. The provider's interim payment rate is an estimate only and shall not bind the department in any way in the final rate determination under (1) and (5).

(5) The provider's final rate as provided in (1) shall be determined based upon the provider's cost report for the rate

year filed in accordance with ARM 37.40.346, after desk review or audit by the department's audit staff. The difference between actual includable cost allocable to services to medicaid residents, as limited in (2), and the total amount paid through the interim payment rate will be settled through the overpayment and underpayment procedures specified in ARM 37.40.347.

(6) Following the sale of an intermediate care facility for the mentally retarded after April 5, 1989, the new provider's property costs will be the lesser of historical costs or the rate used for all other intermediate care facilities, subject to the limitations in 42 USC 1396a(a)(13)(C). (History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1995 MAR p. 1227, Eff. 7/1/95; TRANS, from SRS, 2000 MAR p. 489.)

37.40.337 REIMBURSEMENT TO OUT-OF-STATE FACILITIES

(1) The department will reimburse nursing facilities located outside the state of Montana for nursing facility services and any other reimbursable services or supplies provided to eligible Montana medicaid individuals at the medicaid rate and upon the basis established by the medicaid agency in the state in which the facility is located.

(2) The Montana medicaid program will pay for nursing facility services or related supplies provided to eligible Montana medicaid individuals in nursing facilities located outside the state of Montana only when one of the following conditions is met:

(a) because of a documented medical emergency, the resident's health would be endangered if he or she was to return to Montana for medical services;

(b) the services required are not provided in Montana;

(c) the required services and all related expenses are less costly than if the required services were provided in Montana;

(d) the recipient is a child in another state for whom Montana makes adoption assistance or foster care assistance payments; or

(e) the department determines that it is general practice for recipients in the resident's particular locality to use

medical resources located in another state.

(3) To receive payments, the out-of-state provider must enroll in the Montana medicaid program. Enrollment information and instructions may be obtained from the department's fiscal intermediary, Consultec, at P.O. Box 4286, Helena, MT 59604-4286.

(4) The department will reimburse a nursing facility located outside the state of Montana under the Montana medicaid program only if, in addition to meeting other applicable requirements, the facility has submitted to the department the following information:

(a) a physician's order identifying the Montana resident and specifically describing the purpose, cause and expected duration of the stay;

(b) for nursing facility services, copies of documents from the facility's state medicaid agency establishing or stating the facility's medicaid per diem rate for the period the services were provided;

(c) for separately billable items, copies of documents from the facility's state medicaid agency establishing or stating the medicaid reimbursement payable for such items for the period the items were provided;

(d) a properly completed level I screening form for the resident, as required by ARM 37.40.201, et seq.;

(i) To the extent required by ARM 37.40.201, et seq., a level I screening must be performed prior to entry into the nursing facility to determine if there is a diagnosis of mental illness or mental retardation and if so, to conduct assessments which determine the resident's need for active treatment. A level I screening form may be obtained from the department.

(e) a copy of the preadmission-screening determination for the resident completed by the department or its designee;

(i) Payment will be made for services no earlier than the date of referral for screening or the date of screening, whichever is earlier.

(f) the resident's full name, medicaid ID number and dates of service;

(g) a copy of the certification notice from the facility's state survey agency showing certification for medicaid during the period services were provided; and

(h) assurances that, during the period the billed services

were provided, the facility was not operating under sanctions imposed by medicare or medicaid which would preclude payment.

(5) Reimbursement to nursing facilities located outside the state of Montana for medicare coinsurance days for dually eligible medicaid and medicare individuals shall be limited to the per diem rate established by the facility's state medicaid agency, less the medicaid recipient's patient contribution. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1998 MAR p. 1749, Eff. 6/26/98; TRANS, from SRS, 2000 MAR p. 489.)

37.40.338 BED HOLD PAYMENTS (1) Except as provided in (6) through (9) for therapeutic home visits, payment will be made to a provider for holding a bed for a resident only if:

(a) the provider's facility is full and has a current waiting list of potential residents during each such bed day claimed for reimbursement;

(b) the resident for whom the bed is held is temporarily receiving medical services outside the facility, except in another nursing facility, and is expected to return to the provider;

(c) the cost of holding the bed will evidently be less costly than the possible cost of extending the hospital stay until an appropriate long term care bed would otherwise become available; and

(d) the provider has received written approval from the department's senior and long term care division as provided in (4). (2) For purposes of (1), a provider will be considered full if: (a) all medicaid certified beds are occupied or being held for a recipient who is either temporarily receiving medical services outside the provider's facility or outside the facility on a therapeutic home visit; or

(b) as to gender, if all appropriate, available beds are occupied or being held. For example, if all beds are occupied or held except for one semi-private bed in a female room, the provider is full for purposes of hold days for male recipients.

(3) For purposes of (1), the provider must maintain and, upon request, provide to the department or its agents documentation that the absence is expected to be temporary and of